Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PARK CITIES SURGERY CENTER
6901 SNIDER PLAZA #300
UNIVERSITY PARK TX 75205

Respondent Name
HARTFORD ACCIDENT & INDEMNITY

Carrier's Austin Representative Box
Box Number 47

MFDR Tracking Number
M4-12-2648-01

MFDR Date Received
APRIL 13, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier did not pay claim according to the ASC fee schedule."

Amount in Dispute: $3153.96

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Paid in accordance with Rule 134.402(b)(6), 9D) & (f). Please see attached." The respondent attached a copy of the Physician's Medicare Part B Policy regarding Endoscopic Surgery.

Response Submitted by: The Hartford, 300 S State St., Syracuse, NY 13202

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 1, 2012	ASC Services for CPT code 29807-LT	$3239.98	$3239.98
	ASC Services for CPT code 29821-LT-59	$2420.37	$2420.37
	ASC Services for CPT code 23410-LT	$559.16	$559.16
	ASC Services for CPT code 29826-LT-59	-($3065.55)	-($3065.55)
TOTAL		$3153.96	$3153.96

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.

2. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated March 8, 2012
   - W1-If an endsocpy procedure is performed on the same day as another and within the same family, payment will be 100% for the highest RVU. All other procedures are reduced by the value of the endobase code for that family.
   - W1-Workers compensation state fee schedule adjustment. The modifier billed with this procedure is not valid for the primary service.

   Explanation of benefits dated March 29, 2012
   - 193-Original payment decision is being maintained. Reimbursement for your no additional monies are being paid at this time. Bill has been paid according to state fee guidelines or rules and regulations.
   - W1-Workers compensation state fee schedule adjustment. Subject to multiple procedure discounts and is paid at 100 percent of the fee schedule amount per the Texas physician fee schedule, Medicare guidelines.

Issues

1. Did the respondent support reduction of payment for CPT codes 29807-LT, 29821-LT-59 and 29826-LT-59 based upon Physician's Medicare Part B Policy regarding Endoscopic Surgery?
2. Is the requestor entitled to additional reimbursement for CPT code 29807?
3. Is the requestor entitled to additional reimbursement for CPT code 29821-LT-59?
4. Is the requestor entitled to additional reimbursement for CPT code 23410-LT?
5. Is the respondent entitled to a refund for CPT code 29826-LT-59?

Findings

1. The explanation of benefits indicate that the respondent reduced payment for code 29807-LT, 29821-LT-59 and 29826-LT-59 based upon "W1-If an endsocpy procedure is performed on the same day as another and within the same family, payment will be 100% for the highest RVU. All other procedures are reduced by the value of the endobase code for that family."

   The respondent submitted copies of the Physician's Medicare Part B Policy regarding Endoscopic Surgery to support the reduction.

   The requestor wrote in the letter requesting reconsideration that "The EOB states that the Medicare endoscopy guidlelines do not apply to Texas A.S.C. Workers Compensation claims, secondiary procedures are paid @ 50% of the fee schedule allowed amount."

   28 Texas Administrative Code §134.402(d) states " For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section."

   Trailblazers Health Enterprises, LLC, 2012 ASC Manual states "Each surgical procedure has its own CPT code. When more than one surgical procedure is performed in the same operative session, special payment rules apply even if the services have the same CPT code number.

   When the ASC performs multiple surgical procedures in the same operative session that are subject to the multiple procedure discount, Medicare will allow 100 percent of the highest paying surgical procedure on the claim plus allow 50 percent of the applicable payment rate(s) for the other ASC-covered surgical procedures subject to the multiple procedure discount that are furnished in the same session. The OPPS/ASC Final Rule for the relevant payment year specifies whether a surgical procedure is subject to multiple procedure discounting for that year. Final payment is subject to the usual copayment and deductible provision."

   The Division finds that the reduction of payment for ASC services based upon the Physician's Medicare Part B Policy regarding Endoscopic Surgery is not supported.

2. 28 Texas Administrative Code §134.402(f)(1)(A) states "The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register*. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (1) Reimbursement for non-device intensive procedures shall be: (A) The Medicare ASC facility reimbursement

amount multiplied by 235 percent."

CPT code 29807 is defined as "Arthroscopy, shoulder, surgical; repair of SLAP lesion."

The MAR for CPT code 29807 is $5370.33 ($2,285.25 X 235%). The respondent paid $2088.10. The difference between the MAR and amount paid is $3282.23. The requestor is seeking medical dispute resolution for $3239.98 for this code; this amount is recommended for additional reimbursement.

3. CPT code 29821is defined as "Arthroscopy, shoulder, surgical; synovectomy, complete."

   Per NCCI edits, CPT code 29821 is a component of code 23410; however, a modifier is allowed to differentiate this service. The requestor used modifier 59.

   Modifier 59 is defined as "Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used."

   A review of the operative report supports a separate procedure; therefore, the use of modifier 59 is supported.

   CPT code 29821 is subject to multiple procedure discounting.

   The MAR for CPT code 29821-LT-59 is $2685.16 ($2,285.25 X 235%= $5370.33 X 50%). The respondent paid $243.68. The difference between the MAR and amount paid is $2441.48. The requestor is seeking medical dispute resolution for $2420.37 for this code; this amount is recommended for additional reimbursement.

4. CPT code 23410 is defined as" Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute."

   CPT code 23410 is subject to multiple procedure discounting.

   The MAR for CPT code 23410 is $2235.60 (1902.64 X 235% = $4471.20 X 50%). The respondent paid $1658.86. The difference between the MAR and amount paid is $576.74. The requestor is seeking medical dispute resolution for $559.16 for this code; this amount is recommended for additional reimbursement.

5. CPT code 29826 is defined as "Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure)."

   Per NCCI edits, CPT code 29826 is a component of code 23410; however, a modifier is allowed to differentiate this service. The requestor used modifier 59.

   A review of the operative report supports a separate procedure; therefore, the use of modifier 59 is supported.

   CPT code 29826 is subject to multiple procedure discounting.

   The MAR for CPT code 29826-LT-59 is $1396.74 (1188.72 X 235% = $2793.49 X 50%). The respondent paid $4451.30. The difference between the MAR and amount paid is an overpayment of $3054.56. The requestor noted that the overpayment of $3,065.55 was made; therefore, this amount will be considered in the total allowable.

   The Division finds that the requestor is due $3239.98 + $2420.37 + $559.16 - $3065.55 = $3153.96.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports additional reimbursement sought by the requestor. The Division concludes that the requestor supported its position that additional reimbursement is due. As a result, the amount ordered is $3153.96.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $3153.96 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		6/14/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.